# Proposed Kansas Health Homes Quality Goals and Measures

## June 2013 Draft

| Service Goal | Measure | Measure Category | Source | Numerator | Denominator | Notes |
|---|---|---|---|---|---|---|
| 1. Reduce utilization associated with inpatient stays | Decrease in Institutional Care Utilization | Clinical Outcomes | RFP/Att. J, p. 25, 43, 46, 50, 54, 57 | The number of members utilizing inpatient psychiatric services, including state psychiatric facilities and private inpatient mental health services. | The number of members that were Medicaid or CHIP eligible and continuously enrolled for 11 of 12 months during the measurement period. | |
| | Inpatient Utilization—General hospital/Acute | Clinical Outcomes | HEDIS 2012 | HEDIS specifications | HEDIS specifications | |
| | Plan- All Cause Re-admission | Quality of Care | HH Core Measure | Count the number of Index Hospital Stays with a readmission within 30 days for each age, gender, and total combination | Count the number of Index Hospital Stays for each age, gender, and total combination | |
| | Ambulatory Care-Sensitive Condition Admission | Quality of Care | HH Core Measure | Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years | Total mid-year population under age 75 | |
| 2. Improve Management of Chronic Conditions | HBa1C Testing | Clinical Outcomes | P4P HEDIS | An HbA1c test performed during the measurement year as identified by claim/encounter or automated laboratory data. | The eligible population | |
| | LDL-C Screening | Clinical Outcomes | HEDIS | An LDL-C test performed during the measurement year as identified by claim/encounter or automated laboratory data. | The eligible population | |
| | Follow-up after Hospitalization for Mental Illness | Quality of Care | HH Core Measure, HEDIS | An outpatient visit, intensive outpatient encounter, or partial hospitalization (refer | Members 6 years of age and older discharged alive from an acute inpatient | |

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| | | | | to Table FUH-C in the original measure documentation for codes to identify visits) with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge. | setting (including acute care psychiatric facilities) with a principal mental health diagnosis on or between January 1 and December of the measurement year | |
| | Adult Body Mass Index (BMI) Assessment | Clinical Outcomes | HH Core Measure ACA #23 | Body mass index documented during the measurement year or the year prior to the measurement year | Members 18-74 of age who had an outpatient visit | Percentage of members 18-74 years of age who had an outpatient visit and who had their BMI documented during the measurement year or the year prior to the measurement year |
| | Screening for Clinical Depression and Follow-up Plan | Quality of Care | HH Core Measure ACA #23 | Total number of patients from the denominator who have follow-up documentation | All patients 18 years and older screened for clinical depression using a standardized tool | Percentage of patients aged 18 years and older screened for clinical depression using a standardized tool AND follow-up documented |
| | Controlling High Blood Pressure | Clinical Outcomes | SMD 13-001 ACA #23 | The number of patients in the denominator whose most recent, representative BP is adequately controlled during the measurement year. For a member's BP to be controlled, both the systolic | Patients 18-85 with hypertension. A patient is considered hypertensive if there is at least one outpatient encounter with a diagnosis of HTN during the first six months of the | The percentage of patients 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was |

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| | | | | and diastolic BP must be <140/90mm Hg. | measurement year. | adequately controlled (<140/90) during the measurement year. |
| 3. Improve Care Coordination | Increased Integration of Care | Quality of Care | P4P RFP/Att. J, p. 19, 43,46, 50, 54, 57 | The number of members whose case manager and/or other primary providers reported, through the survey tool, a moderate or high level of clinical integration of care. | The number of members who were Medicaid or CHIP eligible and received HCBS waiver services, specialized rehabilitation MH services, or discharged from SUD services during the measurement period | |
| | Initiation and Engagement of Alcohol and Other Drug Dependence Treatment | Quality of Care | HH Core Measure ACA #23 | "Initiation of AOD Dependence Treatment: Members with initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of diagnosis. | Members 13 years of age and older as of December 31 of the measurement year with a new episode of AOD during the intake period, reported in two age stratifications (13-17 years, 18+ years) and a total rate. The total rate is the sum of the two numerators divided by the sum of the two denominators. | Percentage of adolescents and adults members with a new episode of alcohol or other drug (AOD) dependence who received the following:<br>• Initiation of AOD treatment.<br>• Engagement of AOD treatment |
| | TOBACCO USE ASSESSMENT<br><br>Percentage of patients aged 18 and over who were queried about any and all forms of tobacco use at least once within 24 months (measure at intervals of 6 months; 12 months; 18 months; and | Quality of Care | HRSA Specifications | Number of patients in the denominator for whom documentation demonstrates that patients were queried about their tobacco use one or more times during their most recent visit **OR** within 24 months of the most recent visit. | Number of patients who were 13 years of age or older during the measurement year, seen after 18th birthday, with at least one medical visit during the reporting year, and with at least *two* medical visits in the last three years ,**OR** a sample of these patients (FYI—this | |

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| | 24 months) | | | | means a random sample of 70 performed using their rules). For measurement year 2012, this includes patients with a date of birth on or before December 31, 1994. | |
| 4. Improve transitions of care among primary care and community providers and inpatient facilities | Inpatient Utilization—General hospital/Acute Care (HEDIS) | Clinical Outcomes | HEDIS | HEDIS specifications | HEDIS specifications | This measure summarizes utilization of inpatient care and services in total inpatient, medicine, surgery, and maternity. |
| | Care Transition- Transition Record Transmitted to Health Care Professional | Quality of Care | HH Core Measure | Patients for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge | All patients, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self-care or any other site of care | |

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| | Follow-up after Hospitalization for Mental Illness | Quality of Care | HH Core Measure, HEDIS | An outpatient visit, intensive outpatient encounter, or partial hospitalization (refer to Table FUH-C in the original measure documentation for codes to identify visits) with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge. | Members 6 years of age and older discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis on or between January 1 and December of the measurement year | |

# Required CMS Core Quality Measures

| Measure Title | Measure Definition | Source | Numerator | Denominator | Notes |
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| 1. Adult Body Mass Index (BMI) Assessment | Percentage of members 18-74 years of age who had an outpatient visit and who had their BMI documented during the measurement year or the year prior to the measurement year | SMD 13-001 ACA #23 | Body mass index documented during the measurement year or the year prior to the measurement year | Members 18-74 of age who had an outpatient visit | |
| 2. Ambulatory Care-Sensitive Condition Admission | Ambulatory care sensitive conditions: age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission to the hospital, per 100,000 population under age 75 years. | SMD 13-001 ACA #23 | Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years | Total mid-year population under age 75 | |
| 3. Care Transition – Transition Record Transmitted to Health care Professional | Care transitions: percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge. | SMD 13-001 ACA #23 | Patients for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge | All patients, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self-care or any other site of care | |
| 4. Follow-Up After Hospitalization for Mental Illness | Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge. | SMD 13-001 ACA #23 | An outpatient visit, intensive outpatient encounter, or partial hospitalization (refer to Table FUH-C in the original measure documentation for codes to identify visits) with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of | Members 6 years of age and older discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis on or between January 1 and December of the measurement year | |

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| | | | discharge. | | |
| 5. Plan- All Cause Readmission | For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. | SMD 13-001 ACA #23 | Count the number of Index Hospital Stays with a readmission within 30 days for each age, gender, and total combination | Count the number of Index Hospital Stays for each age, gender, and total combination | |
| 6. Screening for Clinical Depression and Follow-up Plan | Percentage of patients aged 18 years and older screened for clinical depression using a standardized tool AND follow-up documented. | SMD 13-001 ACA #23 | Total number of patients from the denominator who have follow-up documentation | All patients 18 years and older screened for clinical depression using a standardized tool | |
| 7. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment | Percentage of adolescents and adults members with a new episode of alcohol or other drug (AOD) dependence who received the following:<br>• Initiation of AOD treatment.<br>• Engagement of AOD treatment. | SMD 13-001 ACA #23 | "Initiation of AOD Dependence Treatment: Members with initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of diagnosis. | Members 13 years of age and older as of December 31 of the measurement year with a new episode of AOD during the intake period, reported in two age stratifications (13-17 years, 18+ years) and a total rate. The total rate is the sum of the two numerators divided by the sum of the two denominators. | |
| 8. Controlling High Blood Pressure | The percentage of patients 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year. | SMD 13-001 ACA #23 | The number of patients in the denominator whose most recent, representative BP is adequately controlled during the measurement year. For a member's BP to be controlled, both the systolic and diastolic BP must be <140/90mm Hg. | Patients 18-85 with hypertension. A patient is considered hypertensive if there is at least one outpatient encounter with a diagnosis of HTN during the first six months of the measurement year. | |